



# Harlem High School Athletic Packet



Name: \_\_\_\_\_

Grade Level: \_\_\_\_\_

Physical Date: \_\_\_\_\_

## Required Forms to participate in athletics at Harlem High School:

- Preparticipation Physical Evaluation Form
- Insurance Coverage Form
- GHSA Student/Parent Concussion Awareness Form
- GHSA Student/Parent Cardiac Arrest Awareness Form
- Heat/WBGT Activity Guidelines Form
- CCBOE Private Vehicle Permission Form (Optional)
- HHS Emergency Contact Information Form



## ■ PREPARTICIPATION PHYSICAL EVALUATION

### HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Date of examination: \_\_\_\_\_ Sport(s): \_\_\_\_\_

Sex assigned at birth (F, M, or intersex): \_\_\_\_\_ How do you identify your gender? (F, M, or other): \_\_\_\_\_

List past and current medical conditions. \_\_\_\_\_

\_\_\_\_\_

Have you ever had surgery? If yes, list all past surgical procedures. \_\_\_\_\_

\_\_\_\_\_

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional). \_\_\_\_\_

\_\_\_\_\_

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects). \_\_\_\_\_

\_\_\_\_\_

Patient Health Questionnaire Version 4 (PHQ-4)  
*Over the last 2 weeks, how often have you been bothered by any of the following problems? (check box next to appropriate number)*

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Not being able to stop or control worrying	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Feeling down, depressed, or hopeless	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

(A sum of  $\geq 3$  is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?	<input type="checkbox"/>	<input type="checkbox"/>
2. Has a provider ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have any ongoing medical issues or recent illness?	<input type="checkbox"/>	<input type="checkbox"/>
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
4. Have you ever passed out or nearly passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
7. Has a doctor ever told you that you have any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.	<input type="checkbox"/>	<input type="checkbox"/>

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?	<input type="checkbox"/>	<input type="checkbox"/>
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?	<input type="checkbox"/>	<input type="checkbox"/>
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?	<input type="checkbox"/>	<input type="checkbox"/>

BONE AND JOINT QUESTIONS		
	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?	<input type="checkbox"/>	<input type="checkbox"/>
MEDICAL QUESTIONS		
	Yes	No
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?	<input type="checkbox"/>	<input type="checkbox"/>
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant <i>Staphylococcus aureus</i> (MRSA)?	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?	<input type="checkbox"/>	<input type="checkbox"/>
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
22. Have you ever become ill while exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>
23. Do you or does someone in your family have sickle cell trait or disease?	<input type="checkbox"/>	<input type="checkbox"/>
24. Have you ever had or do you have any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL QUESTIONS (CONTINUED)		
	Yes	No
25. Do you worry about your weight?	<input type="checkbox"/>	<input type="checkbox"/>
26. Are you trying to or has anyone recommended that you gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
27. Are you on a special diet or do you avoid certain types of foods or food groups?	<input type="checkbox"/>	<input type="checkbox"/>
28. Have you ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
FEMALES ONLY		
	Yes	No
29. Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

Explain "Yes" answers here.

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**I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.**

Signature of athlete: \_\_\_\_\_

Signature of parent or guardian: \_\_\_\_\_

Date: \_\_\_\_\_

## ■ PREPARTICIPATION PHYSICAL EVALUATION

### PHYSICAL EXAMINATION FORM

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

#### PHYSICIAN REMINDERS

- Consider additional questions on more-sensitive issues.
  - Do you feel stressed out or under a lot of pressure?
  - Do you ever feel sad, hopeless, depressed, or anxious?
  - Do you feel safe at your home or residence?
  - Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
  - During the past 30 days, did you use chewing tobacco, snuff, or dip?
  - Do you drink alcohol or use any other drugs?
  - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
  - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
  - Do you wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height: _____	Weight: _____	
BP: _____ / _____ ( _____ / _____ )	Pulse: _____	Vision: R 20/ _____ L 20/ _____ Corrected: <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance <ul style="list-style-type: none"> <li>Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)</li> </ul>	<input type="checkbox"/>	
Eyes, ears, nose, and throat <ul style="list-style-type: none"> <li>Pupils equal</li> <li>Hearing</li> </ul>	<input type="checkbox"/>	
Lymph nodes	<input type="checkbox"/>	
Heart <sup>a</sup> <ul style="list-style-type: none"> <li>Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)</li> </ul>	<input type="checkbox"/>	
Lungs	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>	
Skin <ul style="list-style-type: none"> <li>Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis</li> </ul>	<input type="checkbox"/>	
Neurological	<input type="checkbox"/>	
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck	<input type="checkbox"/>	
Back	<input type="checkbox"/>	
Shoulder and arm	<input type="checkbox"/>	
Elbow and forearm	<input type="checkbox"/>	
Wrist, hand, and fingers	<input type="checkbox"/>	
Hip and thigh	<input type="checkbox"/>	
Knee	<input type="checkbox"/>	
Leg and ankle	<input type="checkbox"/>	
Foot and toes	<input type="checkbox"/>	
Functional <ul style="list-style-type: none"> <li>Double-leg squat test, single-leg squat test, and box drop or step drop test</li> </ul>	<input type="checkbox"/>	

<sup>a</sup> Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of health care professional: \_\_\_\_\_, MD, DO, NP, or PA

## ■ PREPARTICIPATION PHYSICAL EVALUATION

### MEDICAL ELIGIBILITY FORM

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Medically eligible for all sports without restriction

Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

\_\_\_\_\_  
\_\_\_\_\_  
 Medically eligible for certain sports

\_\_\_\_\_  
\_\_\_\_\_  
 Not medically eligible pending further evaluation

Not medically eligible for any sports

Recommendations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of health care professional: \_\_\_\_\_, MD, DO, NP, or PA

### SHARED EMERGENCY INFORMATION

Allergies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Emergency contacts: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**Columbia County School District**

4781 Hereford Farm Road  
Evans, Georgia 30809  
(706) 541-0650  
[www.ccboe.net](http://www.ccboe.net)

**TO: ALL HIGH SCHOOL AND MIDDLE SCHOOL PARENTS OR LEGAL GUARDIANS**  
**FROM: PAT SULLIVAN, CHIEF FINANCIAL OFFICER**  
**SUBJECT: STUDENT ACCIDENT INSURANCE COVERAGE AND PARENTAL PERMISSION FORM**  
**DATE: JULY 1, 2019**

**PERMISSION FORM AND INSURANCE COVERAGE FOR:**

\_\_\_\_\_  
Student's name Student I.D. number (if available)

\_\_\_\_\_  
Home address

\_\_\_\_\_                      \_\_\_\_\_                      \_\_\_\_\_                      \_\_\_\_\_  
Home phone                      Cell phone                      Birth date                      Grade

to participate in:

- |                                   |                                     |
|-----------------------------------|-------------------------------------|
| _____ High School football        | _____ Middle School football        |
| _____ Other High School Athletics | _____ Other Middle School Athletics |
| _____ High School Cheerleading    | _____ Middle School Cheerleading    |

\_\_\_\_\_  
Parent / Legal Guardian Signature Date

**This form must be signed, dated, and returned to your student's coach or the school office.**

The school's athletic program is an integral part of the total school program and school personnel have devoted great effort to insure participating students are protected in every way possible. However, participation in athletics is not without risk of injury which may range in severity from minor injuries to long-term catastrophic injuries, paralysis, or possibly death.

Columbia County School District requires that all students who participate in High School/Middle School football, all other High School/Middle School athletic programs, and all High School/Middle School cheerleading be covered by medical insurance. This can be done through a policy your child is covered under through your employer or through a policy offered through Columbia County School District by K&K Insurance Group, Inc. (A brochure explaining the coverage offered by K&K Insurance Group, Inc. is attached.) You may also purchase additional coverage on your child through K&K Insurance Group, Inc.

In the area below, please provide your child's medical insurance information. Attach a copy of the front and back of your insurance card. **YOU MUST CHOOSE OPTION #1, #2, OR #3.**

\_\_\_\_\_ 1. My son/daughter \_\_\_\_\_ is covered by medical insurance under the following plan:

Name of Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Amount of deductible: \_\_\_\_\_

Dates of coverage: \_\_\_\_\_ to \_\_\_\_\_

\_\_\_\_\_ 2. I am a member / retired member of the United States Armed Service. My military medical benefits cover my son/daughter and will cover any athletic related injury which may occur to my son/daughter.

\_\_\_\_\_  
Name of Insured

\_\_\_\_\_  
Identification number of insurance

If your child does not have medical insurance and you wish to obtain insurance through K&K Insurance Group, Inc. or wish to obtain additional insurance, please go on-line for faster enrollment [www.studentinsurance-kk.com](http://www.studentinsurance-kk.com) and pay directly on-line or you can send your check directly to the insurance company.

**DO NOT SEND A CHECK TO THE SCHOOL. NOTE:** High School and Middle School football players without medical coverage must obtain football coverage. The **at-school accident coverage, single option** is the minimum coverage required by Columbia County School District for other athletics and cheerleading.

\_\_\_\_\_ 3. I desire to obtain medical insurance coverage through K&K Insurance Group, Inc. I have completed the brochure and mailed a check to the company. My check number is \_\_\_\_\_ and the check is dated \_\_\_\_\_. If you have signed up directly on-line, please attach a copy of your confirmation of insurance coverage.

\_\_\_\_\_ High School football coverage premium \$ \_\_\_\_\_

\_\_\_\_\_ At-School Accident premium \$ \_\_\_\_\_

\_\_\_\_\_ 24-Hour Accident only premium \$ \_\_\_\_\_

\_\_\_\_\_ 24-Hour Accident only (summer only) premium \$ \_\_\_\_\_

In consideration of the option I chose for my son's/daughter's medical coverage for athletic/cheerleading activities, I do hereby agree to hold harmless, release and discharge the Columbia County Board of Education from any responsibilities of any kind whatsoever as a result of any injuries my son/daughter may receive or sustain while participating in athletic/cheerleading activities.

Further, I do hereby authorize school officials to have my son/daughter treated in case of any injury with no financial liability for medical bills to be incurred by the school or school district.

I do hereby grant permission for my child to represent his/her school in approved athletic/cheerleading activities, and to travel with any school team on out of town trips. I agree not to hold the school, school district, or anyone acting on its behalf responsible for any injury occurring to my son/daughter in the proper course of such athletic activity or travel. I acknowledge and accept there are risks of physical injury involved in athletic participation which may result in permanent paralysis, mental disability, and/or death.

Having read the above and by my signature below, I do hereby give my permission for my son/daughter,

\_\_\_\_\_ to participate in the sport(s) checked below:

\_\_\_\_\_ High School football

\_\_\_\_\_ Middle School football

\_\_\_\_\_ Other High School athletics

\_\_\_\_\_ Other Middle School athletics

\_\_\_\_\_ High School cheerleading

\_\_\_\_\_ Middle School cheerleading

\_\_\_\_\_  
Parent / Legal Guardian

\_\_\_\_\_  
Date

**This form must be signed, dated, and returned to your student's coach or the school office.**



# Georgia High School Association Student/Parent Concussion Awareness Form

SCHOOL: Harlem High School

## DANGERS OF CONCUSSION

Concussions at all levels of sports have received a great deal of attention and a state law has been passed to address this issue. Adolescent athletes are particularly vulnerable to the effects of concussion. Once considered little more than a minor “ding” to the head, it is now understood that a concussion has the potential to result in death, or changes in brain function (either short-term or long-term). A concussion is a brain injury that results in a temporary disruption of normal brain function. A concussion occurs when the brain is violently rocked back and forth or twisted inside the skull as a result of a blow to the head or body. Continued participation in any sport following a concussion can lead to worsening concussion symptoms, as well as increased risk for further injury to the brain, and even death.

Player and parental education in this area is crucial – that is the reason for this document. Refer to it regularly. This form must be signed by a parent or guardian of each student who wishes to participate in GHSA athletics. One copy needs to be returned to the school, and one retained at home.

## COMMON SIGNS AND SYMPTOMS OF CONCUSSION

- Headache, dizziness, poor balance, moves clumsily, reduced energy level/tiredness
- Nausea or vomiting
- Blurred vision, sensitivity to light and sounds
- Fogginess of memory, difficulty concentrating, slowed thought processes, confused about surroundings or game assignments
- Unexplained changes in behavior and personality
- Loss of consciousness (NOTE: This does not occur in all concussion episodes.)

**BY-LAW 2.68: GHSA CONCUSSION POLICY:** In accordance with Georgia law and national playing rules published by the National Federation of State High School Associations, any athlete who exhibits signs, symptoms, or behaviors consistent with a concussion shall be immediately removed from the practice or contest and shall not return to play until an appropriate health care professional has determined that no concussion has occurred. (NOTE: An appropriate health care professional may include licensed physician (MD/DO) or another licensed individual under the supervision of a licensed physician, such as a nurse practitioner, physician assistant, or certified athletic trainer who has received training in concussion evaluation and management.)

a) No athlete is allowed to return to a game or a practice on the same day that a concussion (a) has been diagnosed, OR (b) cannot be ruled out.

b) Any athlete diagnosed with a concussion shall be cleared medically by an appropriate health care professional prior to resuming participation in any future practice or contest. The formulation of a gradual return to play protocol shall be a part of the medical clearance.

By signing this concussion form, I give Harlem High School permission to transfer this concussion form to the other sports that my child may play. I am aware of the dangers of concussion and this signed concussion form will represent myself and my child during the 2019-2020 school year. This form will be stored with the athletic physical form and other accompanying forms required by the Columbia County School System.

**I HAVE READ THIS FORM AND I UNDERSTAND THE FACTS PRESENTED IN IT.**

\_\_\_\_\_  
**Student Name (Printed)**

\_\_\_\_\_  
**Student Name (Signed)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Parent Name (Printed)**

\_\_\_\_\_  
**Parent Name (Signed)**

\_\_\_\_\_  
**Date**

# Georgia High School Association

## Student/Parent Sudden Cardiac Arrest Awareness Form

SCHOOL: Harlem High School

### 1: Learn the Early Warning Signs

If you or your child has had one or more of these signs, see your primary care physician:

- Fainting suddenly and without warning, especially during exercise or in response to loud sounds like doorbells, alarm clocks or ringing phones
- Unusual chest pain or shortness of breath during exercise
- Family members who had sudden, unexplained and unexpected death before age 50
- Family members who have been diagnosed with a condition that can cause sudden cardiac death, such as hypertrophic cardiomyopathy (HCM) or Long QT syndrome
- A seizure suddenly and without warning, especially during exercise or in response to loud sounds like doorbells, alarm clocks or ringing phones

### 2: Learn to Recognize Sudden Cardiac Arrest

If you see someone collapse, assume he has experienced sudden cardiac arrest and respond quickly. This victim will be unresponsive, gasping or not breathing normally, and may have some jerking (Seizure like activity). Send for help and start CPI. You cannot hurt him.

### 3: Learn Hands-Only CPR

Effective CPR saves lives by circulating blood to the brain and other vital organs until rescue teams arrive. It is one of the most important life skills you can learn – and it's easier than ever.

- Call 911 (or ask bystanders to call 911 and get an AED)
- Push hard and fast in the center of the chest. Kneel at the victim's side, place your hands on the lower half of the breastbone, one on top of the other, elbows straight and locked. Push down 2 inches, then up 2 inches, at a rate of 10 times/minute, to the beat of the song "Stayin' Alive."
- If an Automated External Defibrillator (AED) is available, open it and follow the voice prompts. It will lead you step-by-step through the process, and will never shock a victim that does not need a shock.

By signing this sudden cardiac arrest form, I give Harlem High School permission to transfer this sudden cardiac arrest form to the other sports that my child may play. I am aware of the dangers of sudden cardiac arrest and this signed sudden cardiac arrest form will represent myself and my child during the 2019-2020 school year. This form will be stored with the athletic physical form and other accompanying forms required by the Columbia County School System.

**I HAVE READ THIS FORM AND I UNDERSTAND THE FACTS PRESENTED IN IT.**

\_\_\_\_\_  
Student Name (Printed)

\_\_\_\_\_  
Student Name (Signed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent Name (Printed)

\_\_\_\_\_  
Parent Name (Signed)

\_\_\_\_\_  
Date



Dear Parent:

The Georgia High School Association requires that each sport that practices or plays outside during extreme heat to have a written policy for conducting practices, and to notify parents of practice times and guidelines used regarding the Wet Bulb Globe Temperature (WBGT) reading.

The WBGT is not the temperature outside. It is a combination measurement including temperature, humidity, and radiant heat.

A scientifically approved instrument that measures Wet Bulb Globe Temperature (WBGT) reading must be utilized at each practice to ensure that the written policy is being followed properly.

WBGT READING	ACTIVITY GUIDELINES & REST BREAK GUIDELINES
<b>UNDER 82.0</b>	Normal activities --Provide at least three separate rest breaks each hour of minimum duration of 3 minutes each during workout
<b>82.0-86.9</b>	Use discretion for intense or prolonged exercise; watch at-risk players carefully; Provide at least three separate rest breaks each hour of a minimum of four minutes duration each.
<b>87.0-89.9</b>	Maximum practice time is two hours. For Football: players restricted to helmet, shoulder pads, and shorts during practice. All protective equipment must be removed for conditioning activities. For all sports: Provide at least four separate rest breaks each hour of a minimum of four minutes each
<b>90.0-92.0</b>	Maximum length of practice is one hour, no protective equipment may be worn during practice and there may be no conditioning activities. There must be 20 minutes of rest breaks provided during the hour of practice.
<b>OVER 92</b>	No outdoor workouts; Cancel exercise; delay practices until a cooler WBGT reading occurs

Please sign below acknowledging receipt of this letter. We need to make sure that each parent is informed and notified of this GHSA policy. If you have any questions regarding practice times or the WBGT reading, please contact your child's coach.

Parent Signature

Date

Student Signature

Date

FORM 2  
SCHOOL-SANCTIONED EVENT

R E L E A S E

This is to certify, in writing, that I, \_\_\_\_\_ (hereafter known as the PARENT), grant permission for my son or daughter, \_\_\_\_\_, to be transported by a private vehicle not owned or operated by the Columbia County School System (hereafter known as the SCHOOL SYSTEM). This permission shall last for the duration of the school year. This Release applies to any private transportation where the driver is my son or daughter or any other adult individual. The owner or driver of the private vehicle is responsible for his own personal automobile insurance. Proof of automobile insurance coverage and a copy of the individual's driver's license must be furnished to the school office prior to each trip. The PARENT releases all liability against the SCHOOL SYSTEM, including all claims, costs, damages, expenses and causes of actions, arising from any act or occurrence and on account of all personal injury or disability occurring as the result of any incident occurring during the transportation time. This Release shall be on behalf of the PARENT, both individually and in a representative capacity, and the STUDENT individually.

Under no circumstances may this Release be waived, modified, or otherwise altered unless previously approved in writing by the SCHOOL and the PARENT. Any attempt at an oral modification of this agreement shall be treated as void and unenforceable.

\_\_\_\_\_  
(Parent/Legal Guardian)

\_\_\_\_\_  
(Date)

(Revised 10-22-07)

AN EQUAL OPPORTUNITY SYSTEM

